Saturday 15 January 2000

BMJ

A good death

An important aim for health services and for us all

> The art of living well and dying well are one.
>
> Epicurus

> Death is one of the attributes you were created with; death is part of you. Your life's continual task is to build your death.
>
> Montaigne

Are you ready to die? If not, then you might begin some preparation. Every *BMJ* reader will die this century, and death is constantly beside us. Montaigne urged, "One should be ever booted and spurred and ready to depart." Yet that has not been the attitude of the past 50 years, and modern medicine may even have had the hubris to suggest implicitly, if not explicitly, that it could defeat death.[1] If death is seen as a failure rather than as an important part of life then individuals are diverted from preparing for it and medicine does not give the attention it should to helping people die a good death. We need a new approach to death, and the debate of the age on older people has provided a clarion call: "We believe it is time to break the taboo and to take back control of an area [death] which has been medicalised, professionalised, and sanitised to such an extent that it is now alien to most people's daily lives."[2]

To bring death back to the centre of life would not, of course, be new. Ivan Illich traced the history of death in his critique of modern medicine, *Limits to Medicine*.[1] The dance of the dead painted on a cemetery wall in Paris in 1424 showed each character dancing with his or her own death throughout life. One of the first books published by William Caxton, England's first printer, was a manual of how to die. It remained a bestseller for two centuries. It was not until after the Reformation that European death became macabre, and Francis Bacon was the first to suggest that doctors might hold death at bay. Earlier Arab and Jewish doctors had thought it blasphemous for doctors to attempt to interfere with death. For Paracelsus death was "a return to the womb." Nevertheless, death has become medicalised, reaching its apotheosis perhaps with the prolonged death, reported minutely by the media, of Spain's dictator General Franco. Most people in Britain today die in hospital, even though they say they would prefer to die at home, and a soulless death in intensive care is the most modern of deaths.

Yet the call from the debate of the age seems to be part of a broader tendency to remove the taboo on death. Elisabeth Kubler-Ross, Cicely Saunders, and other pioneers of palliative care have been arguing for 30 years that special care should be offered to the dying.[3 4] There is, however, something paradoxical about creating a specialty to cater for something that happens to us all. The trend now is for the lessons learnt by palliative care physicians to be reclaimed by everybody. We have seen the beginnings with frank accounts of dying by journalists,[5] pictures of a person dying on television,[6] and guidebooks on dying well.[7 8]

But what is the state of dying in Britain today? Sadly, nobody can answer that question with confidence. We have reliable and detailed statistics on life expectancy, age at death, and place and cause of death, but we know little about the experience of death. For the minority who die under the care of palliative care teams it is probably good, but there is a suspicion that for the majority who die in acute hospitals or nursing homes the experience is bad. The newspapers are full of anecdotes of bad deaths in British hospitals, and a survey published in the *BMJ* in 1994 showed that care of the dying in hospital was poor.[9] That study was conducted in 1983, and letters after publication debated whether its bleak findings were still true.[10 11]

Debate over whether people are dying badly or well obviously depends on a definition of a good death. It is clearly more than being free of pain, and three themes that emerged constantly in the debate of the age were control, autonomy, and independence.[2] The authors of the final report on *The Future of Health and Care of Older People* have identified 12 principles of a good death (see box).[2] These are excellent principles and should surely be incorporated into the plans of individuals, professional codes, and the aims of institutions and

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Principles of a good death

- To know when death is coming, and to understand what can be expected
- To be able to retain control of what happens
- To be afforded dignity and privacy
- To have control over pain relief and other symptom control
- To have choice and control over where death occurs (at home or elsewhere)
- To have access to information and expertise of whatever kind is necessary
- To have access to any spiritual or emotional support required
- To have access to hospice care in any location, not only in hospital
- To have control over who is present and who shares the end
- To be able to issue advance directives which ensure wishes are respected
- To have time to say goodbye, and control over other aspects of timing
- To be able to leave when it is time to go, and not to have life prolonged pointlessly

whole health services. Dying and death are being included in national care standards in England, and we clearly need to monitor how people die.

But the focus must not all be on the process of dying. Death should be brought more into life, and the report also recommends how this can be done. One suggestion is to introduce death education into schools. Another is to improve the quality and relevance of funerals. The National Funerals College has introduced the Dead Citizen's Charter, and it criticises many modern funerals for being "hypocritical, bureaucratic, dull, impersonal, and hurried."[12] A good funeral is a life enhancing experience, and I suggest that you think about yours now. "Make way for others," advises Montaigne, "as others did for you. Imagine how much more painful would be a life which lasts for ever."

Richard Smith *editor, BMJ*

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3 Kubler-Ross E. *On death and dying*. London: Tavistock, 1970.
4 Saunders C, Summers DH, Teller N. *Hospice: the living idea*. London: Edward Arnold, 1981.
5 Picardie R. *Before I say goodbye*. London: Penguin, 1998.
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Sore throats and antibiotics

Applying evidence on small effects is hard; variations are probably inevitable

The liberal use of antibiotics for sore throats is increasingly frowned on.[1] There are three reasons why a clinician might use antibiotics for sore throat: to reduce the risk of complications, to shorten (or reduce the severity of) symptoms, and because of factors related to the consultation (perceived patient demand, ways of terminating the consultation, and so on). Nearly 30 years ago Howie showed a huge variation in different general practitioners' use of antibiotics for sore throat.[2] Have general practitioners been thirsting for information on which to base their management? The notion that summarising evidence about an area of care will result in a sort of regulation of doctors' management appears to be naive. A Cochrane review summarising the advantages of antibiotics for sore throat has been available for several years.[3] But there is nothing to suggest that there is less variation in practice. General practitioners do not access evidence based information well.[4]

Perhaps this evidence based information is inappropriate or unhelpful? What does it show? Antibiotics reduce the incidence of both suppurative and non-suppurative complications of sore throat. A new study from Holland, published in this week's issue (p 150), has confirmed that antibiotics protect against quinsy.[5] This apparently well conducted study also confirms the previously established benefits of antibiotics in reducing the duration of symptoms. However, the trial shows something new: that putting patients on seven—rather than three—days of treatment is more effective at reducing the duration of symptoms. The data are puzzling because this became apparent before day 3—when the treatments were identical. (They could be reanalysed to see how the combined penicillin treatments differ from the control up to day 3.) There was a greater effect than in previous studies. Perhaps these Dutch general practitioners focused on more severe cases than did those in other countries in the past—they have a general reputation for parsimony with antibiotics.[6] New data may arrive in time to help define subgroups of people with sore throat who would derive greater benefit from antibiotics.

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But this is fine detail. Broadly, the evidence does more than simply establish a statistical benefit for antibiotics in complications and symptom control: it also gives an estimate of the size of the effects. The benefit is so modest that one can dispute its clinical importance. This is because the size of the effect is small (however statistically significant) or because the chance of suffering complications is so tiny that even a reasonable relative reduction conferred by antibiotics yields a similarly unimportant absolute benefit.

This brings the result of the evidence into an area of decision making that is complicated. There is no single course of action that will suit all—or even most—patients. The evidence must be applied in different ways according to different local conditions. These will include environmental factors (such as places in the world where acute rheumatic fever is so common as to be a central consideration), history (for example, previous middle ear infections), and social factors. General practitioners put as much weight on social factors as on the physical examination in deciding whether or not to use antibiotics.[7] Both patients and their doctors dance delicately around the complicated negotiation of antibiotics for upper respiratory infections, each aware of the others' sensibilities.[8]

If that sounds inexcusably non-objective and chaotic, consider this. At some point the benefits and harms resulting from treatments (together with doctors' additional worries to mix into the decision, including emerging antibiotic resistance[1] and costs to society) are so finely balanced that patients and their doctors must decide on a choice that is likely to be tipped one way by personal preference alone.

To expect a one line answer from the evidence (a guideline, for example) is to ask too much. Nor is there any suggestion that doctors want to abdicate that

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